Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH CARE PLLC
2821 LACKLAND RD SUITE 300
FORT WORTH TX 76116

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-12-0647-01

MFDR Date Received
OCTOBER 28, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim originally billed on 03/17/11 with CPT Code G0434 QW which was denied by insurance on 04/28/11 The submitted documentation does not support the service billed. We will re-evaluate this upon receipt of clarifying information. Accurate coding is essential for reimbursement, CPT billed incorrectly services are not reimbursable as billed. We submitted a Correctly Claim on 06/20/11 with a new CPT Code 80104 QW. Insurance denied the Corrected Claim on 07/15/11 as past timely filing. Per the original denial, the claim would be re-evaluated upon receipt of clarifying information regarding the CPT Code, our Corrected Claim should not have been denied for past timely filing."

Amount in Dispute: $36.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent, or its' agent, did not submit a response to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 9, 2011	Drug Screening	$36.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.

4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.

The services in dispute were reduced/denied by the respondent with the following reason codes:

- 29 – The time limit for filing has expired.
- 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05.
- 16 – Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 225 – The submitted documentation does not support the service being billed. We sill re-evaluate this upon receipt of clarifying information.
- 724 – No additional payment after a reconsideration of services.

Issues

1. Did the requestor file the corrected bill timely?
2. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Administrative Code §133.20(g) a health care provide may correct and resubmit as a new bill and incomplete bill that has been returned by the insurance carrier. According to the requestor position statement they originally billed CPT Code G0434-QW; however, review of the submitted documentation supports that the requestor initially billed CPT Code 80104-QW as reflected on the submitted original EOBs. The requestor was contacted and the Division found that the requestor submitted a corrected bill on June 20, 2011, using CPT Code G9434QW.

   28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April 26, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.